



## Early Head Start Oral Health Form—Children

### Patient Information

Child's name

Date of birth

 This practice is the child's dental home: ☐ Yes ☐ No

### Current Oral Health Status

 Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free) ☐ N/A

 Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

 Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

### Oral Health Care Services Delivered During Visit

#### Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No  
 X-rays: ☐ Yes ☐ No  
 Risk assessment: ☐ Yes ☐ No  
 Cleaning: ☐ Yes ☐ No  
 Fluoride varnish: ☐ Yes ☐ No  
 Dental sealants: ☐ Yes ☐ No

#### Counseling/Anticipatory Guidance

☐ Yes ☐ No

#### Referral to Specialty Care

☐ Yes ☐ No

 \_\_\_\_\_  
 (Please specify specialist)

#### Restorative/Emergency Care

Fillings: ☐ Yes ☐ No  
 Silver diamine fluoride: ☐ Yes ☐ No  
 Crowns: ☐ Yes ☐ No  
 Extractions: ☐ Yes ☐ No  
 Emergency care: ☐ Yes ☐ No  
 Other: \_\_\_\_\_

(Please specify)

### Future Oral Health Care Services

 All treatment completed: ☐ Yes ☐ No

Next preventative visit: \_\_\_\_\_ / \_\_\_\_\_ (month/year)

 More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: \_\_\_\_

Next treatment appointment date: \_\_\_\_\_

### Additional Information for Parents, Early Head Start Staff, and Medical Providers

### Oral Health Provider's Contact Information and Signature

Provider name (please print)

Phone number

Fax number

Practice name

Address

Provider signature

Date of service